Department of Health Care Finance Fiscal Year 2017-18 Performance Oversight Hearing

Presentation Before the Committee on Health Council of the District of Columbia The Honorable Vincent Gray, Chairperson

February 23, 2017
Washington DC

Presentation Outline

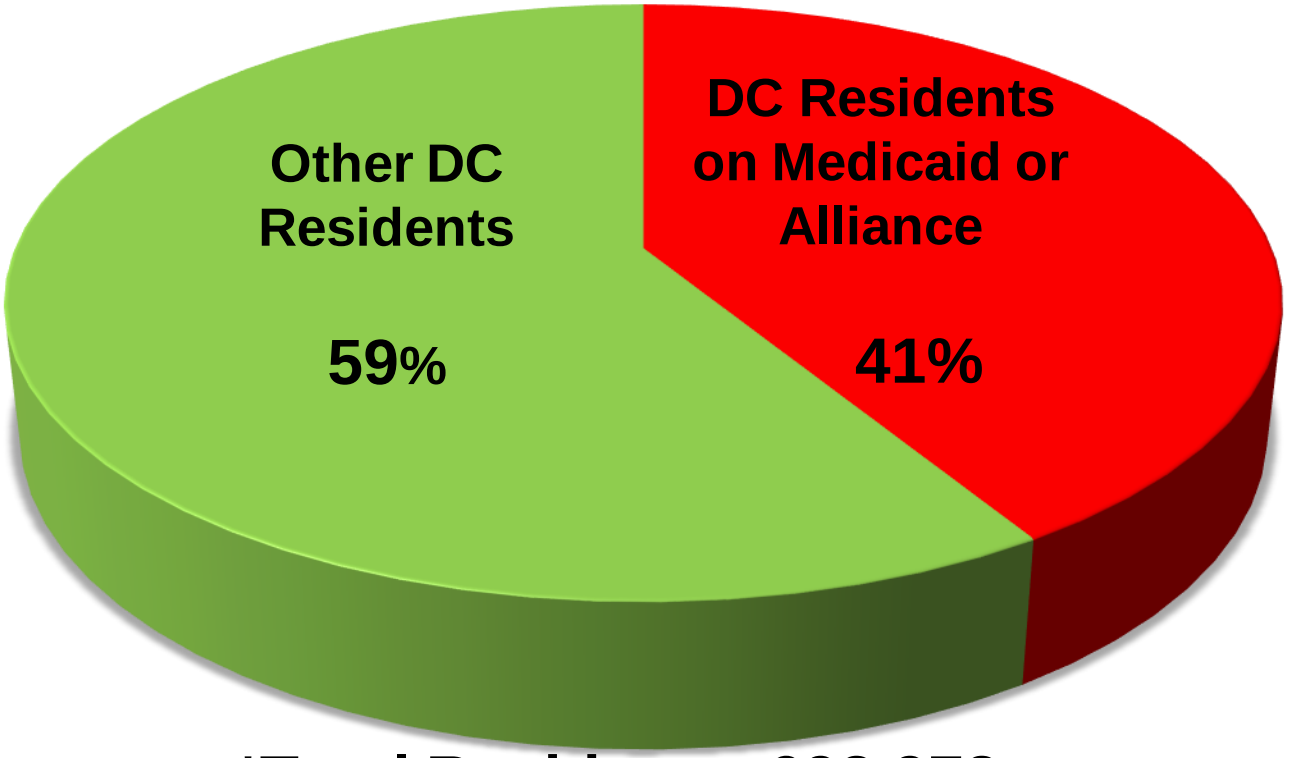
☑ **Agency Mission**

❑ Focus Of DHCF's Oversight Activities

Managed Care Procurement
New System of Care Management
Provider Reimbursement Redesign
Reorganize DCAS Project
New Data Warehouse

❑ Conclusion

DHCF's First Priority Is To Ensure Access To Health Care Through The Medicaid And Alliance Programs That Cover More Than 4 in 10 District Residents

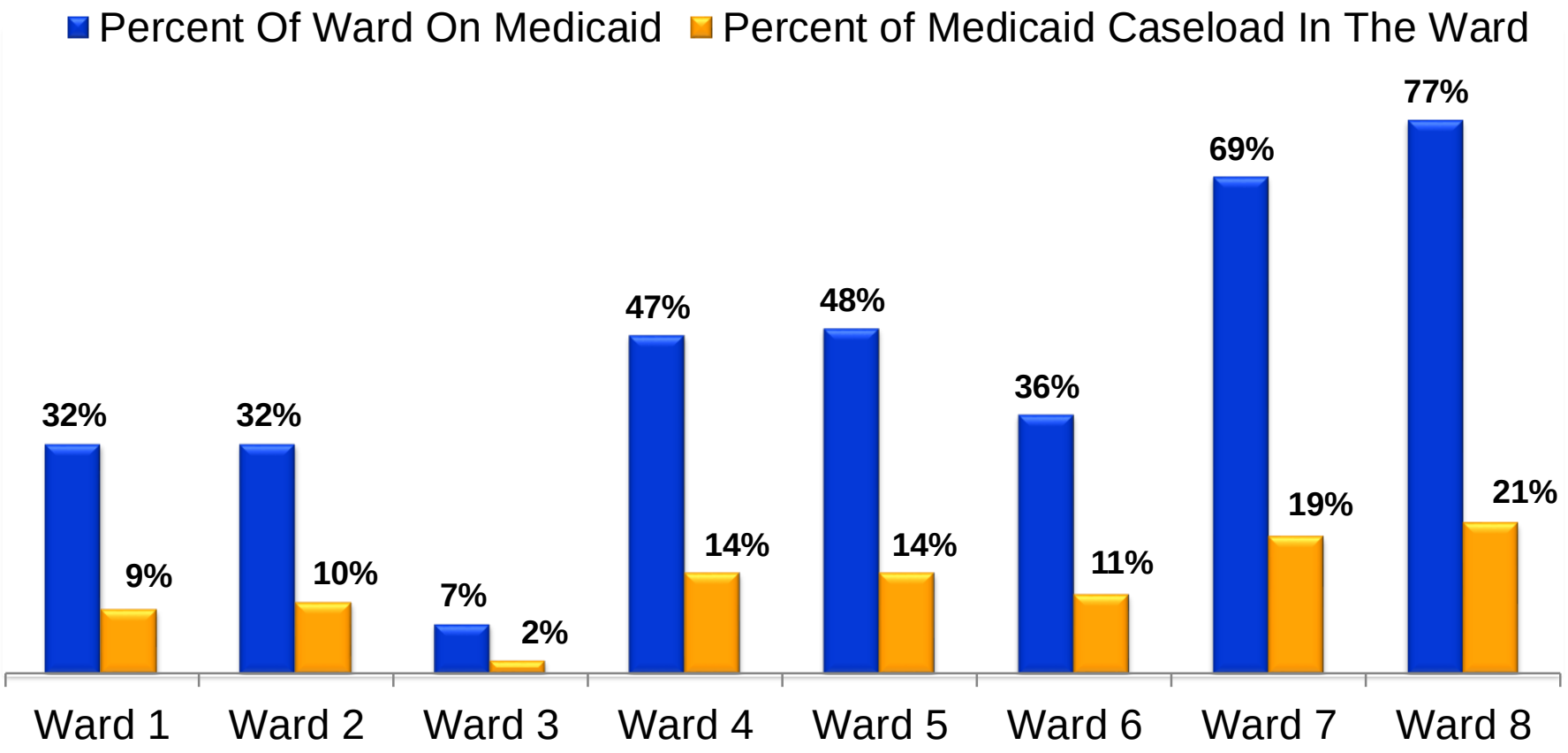


***Total Residents 693,972**

Source: District population estimate from United States Census Bureau. Medicaid and Alliance data reported from DHCF's Medicaid Management Information System (MMIS).

Note: These data exclude District residents who are not United States Citizens and thus the percent of residents on publicly funded health care may be slightly overstated..

Medicaid Enrollment Is Disproportionately Concentrated In The East End Of The City



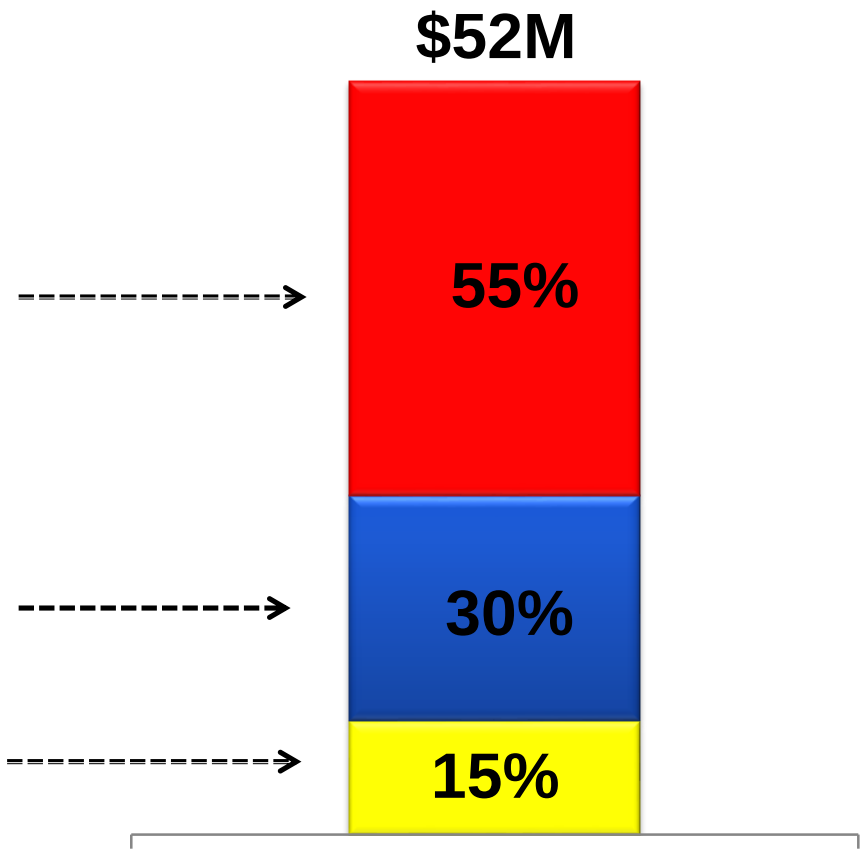
Source: Ward population reported from United States Census Bureau. Medicaid caseload data reported from DHCF's MMIS system.

DHCF's Second Priority Is To Improve Patient Health Outcomes For Medicaid And Alliance Beneficiaries

- With such wide coverage of the District's residents, our budget of more than $3 billion is the largest in local government
  - 96 percent of this amount is dedicated to provider payments
- Although we spend $3 billion on health care, serious questions persist -
  - Is their health status improving? How can we incentivize care quality?
- The focus of service delivery in Medicaid and Alliance is clearly hospital-based care.
  - Spend over $700 million per year on inpatient hospital services with the emergency room often substituting for visits to primary care doctors
- Seven of every 10 visits made by our beneficiaries to hospital emergency rooms (ER) are for non-emergency reasons. That is unacceptably high.

Avoidable Medical Expenses For Medicaid Managed Care Beneficiaries Surpass $50 Million

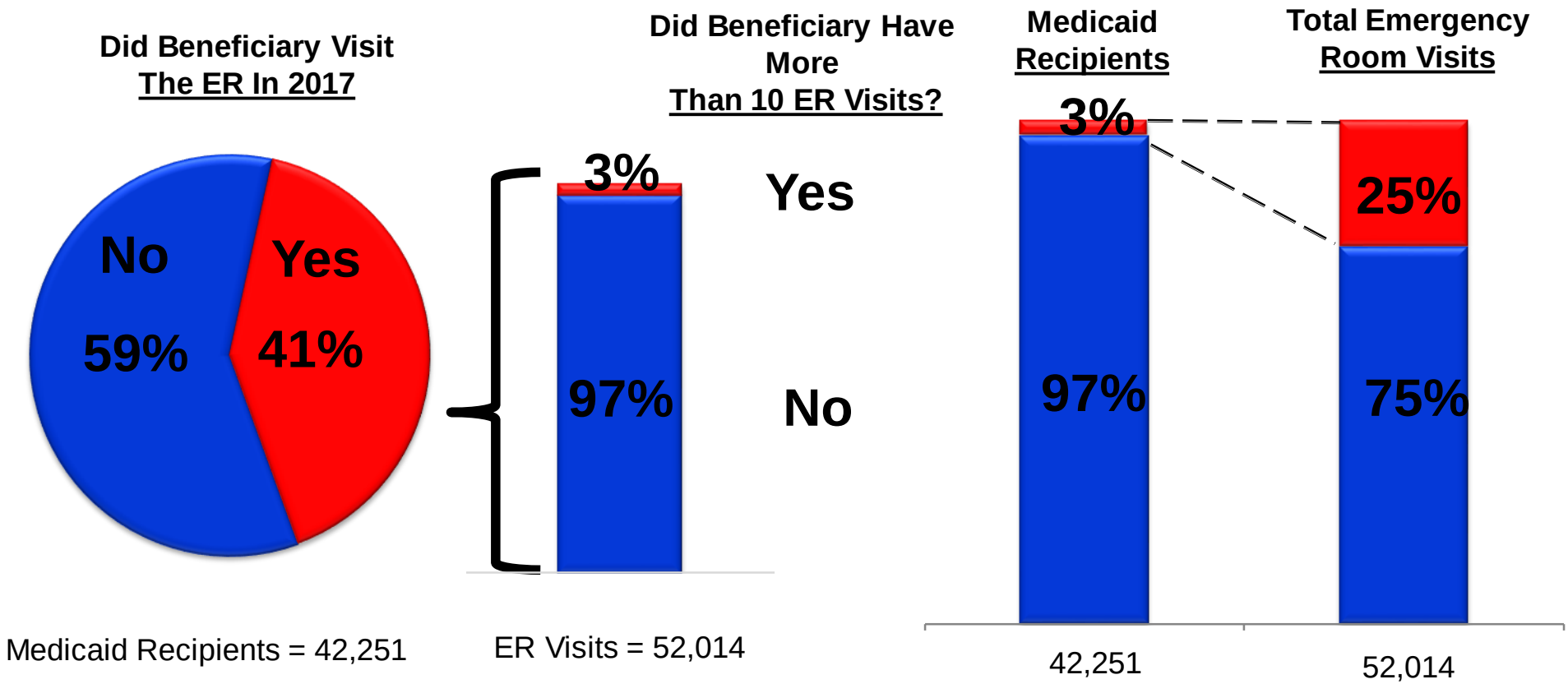
Patient Metrics



Notes: Low acuity non-emergent visits are emergency room visits that could have been potentially avoided , identified using a list of diagnosis applied to outpatient data. Avoidable admissions are identified using a set of prevention quality measures that are applied to discharge data. Readmissions represent inpatient visits that within 30 days of a qualifying initial inpatient admissions.

Source: Mercer analysis of MCO Encounter data reported by the health plans to DHCF.

A Small Portion Of Beneficiaries Are Disproportionately Responsible For High Levels Of Emergency Room Use



Note: For this analysis, Fee-For-Service beneficiaries include only those who were continuously eligible during 2017 with no MCO enrollment and no participation in the long-term care waivers, nursing homes, or Intermediate Care Facilities for Individuals with Intellectual disability.

Source: Medicaid claims from DHCF's MMIS.

DHCF's Final Priority Is To Protect The Integrity Of The Program

- As stewards of the District's tax dollars, we are always concerned about waste, fraud and abuse in publicly funded health care programs.

- Nothing threatens funding for these programs more than evidence of rampant fraud

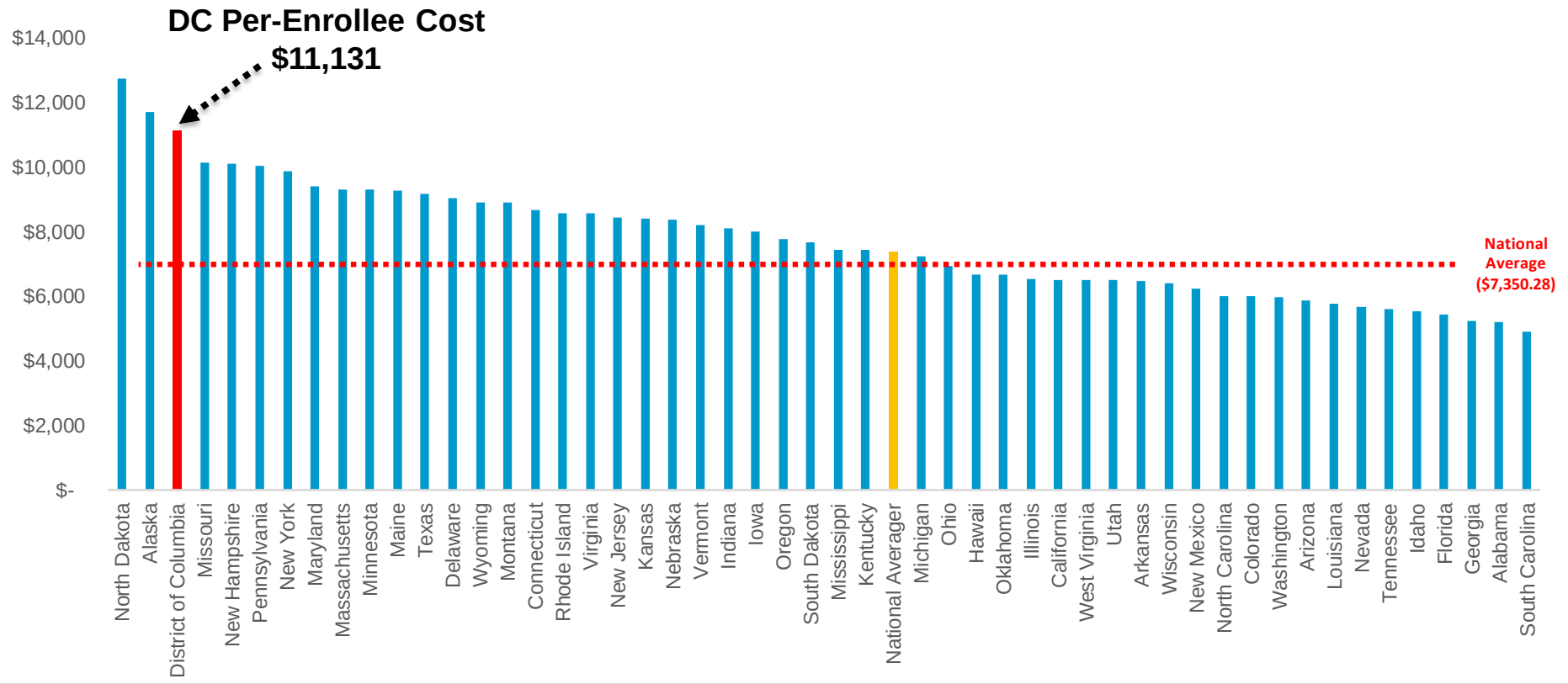
  - Inflates the cost of health care

    - National estimates indicate that fraud adds 10% to possibly as much as 15% to program cost

  - Raises public cynicism about the government's stewardship of their tax dollars

  - Creates pressure on lawmakers to curb spending on these programs

Annual Medicaid Spending Per-Enrollee In The District Is Among The Highest In The Nation



Source: Data referenced from MACPAC's Medicaid Benefit Spending per Full-Year Equivalent Enrollee for Newly Eligible Adult and All Enrollees by State, FY2016 (https://www.macpac.gov/publication/medicaid-benefit-spending-per-full-year-equivalent-enrollee-for-newly-eligible-adult-and-all-enrollees-by-state/)

Presentation Outline

- ❑ Agency Mission

- ☑ **Focus Of DHCF's Oversight Activities**
  - ***Managed Care Procurement***
  - ***New System of Care Management***
  - ***Provider Reimbursement Redesign***
  - ***Reorganize DCAS Project***
  - ***New Data Warehouse***

- ❑ Conclusion

DHCF Is In The Midst Of A Significant Evolution As An Agency

- DHCF's operational complexity requires that we –
  - Seek highly qualified staff
  - Employ the best in technology to support their work efforts
- Evolution has been significant. In 2011, I found an agency that was flat on its back –
  - 40 percent of the positions were vacant
  - Staff morale and productivity levels were astonishingly low, directly feeding a dismal culture of underperformance
  - Work performed in narrow silos by small numbers of staff
  - Employees struggled with inefficient work methods and rudimentary analytical tools.

We Are Building A Culture Of Excellence At DHCF To Responsibly Manage The Districts Publicly-Funded Programs

- In response we launched a major recruitment to fill vacancies with persons who were analytical, motivated, and knowledgeable about with health care

- Worked assiduously on upgrading our information technology capabilities

  - We process roughly 13.5 million provider claims, managed care encounters, and capitated payments annually
  - Data offer a window into the health care needs of our beneficiaries
  - Provides insight into meaningful solutions to possibly address their often-complex health problems

- To do this, we had to build sophisticated enterprise data management systems that –

  - Capably retrieve and seamlessly integrate claims data for internal applications
  - Permits the analysis work designed to support staff efforts in analyzing large volumes of data

The Changes Produced By Our Efforts Are Ubiquitous

- DHCF is growing as a sophisticated operation, fully equipped with -
  - A remarkable executive team an agency fiscal officer, senior level staff and mid-level managers
  - The best in technology to help a talented staff perform their jobs
- We have gradually moved away from the standard hierarchical, top-down model that characterized the early development of DHCF. What is emerging now is a system that rewards those employees who –
  - Can handle projects that require an abundance of subject matter expertise
  - Have sufficient interpersonal skills to work in a coordinated and collaborative manner, and
  - Possess the ability to operate and execute under the pressure of deadlines which we simply cannot afford to miss.
- We have created a culture of problem-solving at DHCF, improving our ability to manage this program and pursue more accurate solutions to complex problems

Five Major Projects Consumed Significant Amounts Of DHCF Attention And Resources In FY2017

1) Procurement of DHCF's $1 billion managed care program;

2) Implementation of My Health GPS – a program to coordinate care and improve health outcomes for some of our members with complex medical difficulties;

3) Executed provider payment reform efforts for nursing homes and Federally Qualified Health Centers (FQHCs);

4) Assumed management control of the District of Columbia Access System (DCAS) – our integrated eligibility system; and,

5) Built a powerful Data Warehouse

DHCF Awarded Contracts To Three Vendors But The Decision Remains Under Protest

- In July 2017, a DHCF procurement team awarded three health plans, separate five-year MCO contracts -- one base year and four option years

- In that same month, MedStar Family Practice (MedStar) filed an instant protest of the contract awards which -

  - Charged that the District's evaluation was unreasonable
  - Alleged that the District conducted misleading discussions

- In December 2017, the Contract Appeals Board (CAB) issued a ruling supporting MedStar's appeal

  - Labeled the scoring by the panel as "arbitrary and capricious"
  - Concluded that the District's determination of Amerigroup's responsibility did not have a reasonable basis

Rationale Offered By Judge In Support Of Board's Ruling

Key Points Cited in Judge's ruling -

- Amerigroup only submitted past performance evaluations of its affiliates work in other states – thus bid was not responsible. The argument -
  - How can a new company without a local office or any officers or employees, perform a contract which was to begin in less than five months' time?
    - It worth noting that Amerigroup, with 7.7 million members, is the largest insurer for public health programs in the nation
- The Judge also found the contracting officer's evaluation of Amerigroup's and AmeriHealth's past performance to be unreasonable
  - Failed to adequately discuss the nature of the offeror's nexus to the affiliates
  - Wanted greater specificity rather than general attestations of affiliate support

Multiple Actions Taken Since Initial CAB Ruling

- The CAB did not order that the solicitation be cancelled. Rather -
  - DHCF was instructed to reevaluate the proposals using the existing record
  - DHCF was prohibited from conducting additional Best and Final Offers (BAFOs) to explore the offeror- affiliate relationship
- Thus, the District could not examine in greater detail, the support that would be provided by the affiliates
- After careful examination, the Office of the Attorney General (OAG) petitioned the DC Superior Court in December 2017 for a review of the CAB decision
  - Requested that the Court find the ruling "arbitrary, capricious, erroneous as a matter of law, and not supported by substantial evidence."
  - Asked the Court to either reverse or set aside the decision of the CAB or, alternatively, remand the case to the Board with instructions to modify its order of corrective action allowing BAFOs

Multiple Actions Taken Since Initial CAB Ruling (continued)

- Two of the three health plans that were awarded contracts have filed separate appeals
- Concomitantly, DHCF's technical team revaluated the proposals according to the CAB's instructions
- OCP's contracting officer reviewed the technical team's consensus report and independently scored each proposal against the evaluation factors
- However, following her reevaluation, the contracting officer determined that she was unable to make any award determinations without first requesting BAFOs to resolve questions such as proposal validity.
- DHCF is holding further action in abeyance pending a ruling from the CAB or, a response by the Superior Court or the Superior Court's ruling on the District's Petition for Review

Care Management Program Created To Improve Patient Outcomes And Lower Cost

- The challenge of managing and coordinating care across providers has been shown to contribute to poor outcomes for Medicaid beneficiaries, especially those in the fee-for-service program

- My Health GPS was established to improve health outcomes while reducing inappropriate hospital utilization and hospital readmissions

- Model - multiple teams of community providers are assigned a group of beneficiaries and asked to fully manage all aspects of their care

  - Benefit design embraces pay for performance component
  - Promoting shared accountability to improve patient health outcomes

Program Launched Last Summer

- My Health GPS program was officially launched on July 1, 2017
  - 12 providers and 33 participating sites with programs in all Wards
  - Unity, Providence Health Services, Whitman Walker, Mary's Center, and Community of Hope are among the larger programs.
  - Programs include nurse care managers, social workers, community health workers, and clinical pharmacists.
- As of February 2018, approximately 3,400 beneficiaries are enrolled - $1.69M billed
- Challenge of the program is practice transformation
  - Integrating innovative technology
  - Asking providers to change the way they deliver care
  - Intimidating shift requires significant assistance from DHCF

DHCF Providing Key Support Role

- We are offering support of this program in several ways
  - Flexibility to design their own staffing models (within some accepted parameters)
  - Supporting the development of new health information exchange tools
    - Patient care snapshot - provides an overview of all the care a patient has received across different settings in the District
- Technical assistance
  - In person meetings
  - Individualized support to help providers adapt to using new technology
  - Identifying new clinical strategies to support patients
  - Conducting more rigorously designed performance evaluations.

DHCF Has Implemented Major Reform Of Nursing Home Payment Methodology

- The current nursing home methodology is beset with problems
  - 12 years old
  - Disincentives for care of bariatric patients and persons who struggle with mental health issues.
  - Has a lengthy audit appeals process frequently resulting in retroactive rate adjustments creating cash management issues for nursing homes.
- New rate methodology –
  - Improves the link between patient acuity and reimbursement
    - Higher payments for sicker residents
    - Reduces administrative burden
    - Puts more money in the system - $29 million
    - Enhances rate transparency
- We anticipate approval soon, allowing a retroactive effective of February 1, 2018.

Similar Rate Change Has Been Put In Place For FQHCs

- Since 2001, federal law required states to reimburse the FQHCs using a Prospective Payment System (PPS) - essentially a bundled payment system
- Overtime, however, PPS rates did not keep pace with inflation
- DHCF built a new payment methodology that aligns reimbursement rates with the providers' service profile and reasonable cost
  - Implement reimbursement for up to 3 same-day visits for certain services.
  - Incorporate value-based payment concepts thorough a quality incentive payment plan
  - Built efficiencies into the payment process that supplement MCO payments to FQHCs with a so-called WRAP payment
  - Establish a claims appeals process
- DHCF worked extensively with the providers on this new rate methodology
  - SPA submitted and final approval obtained in September 2017
  - Remaining challenge is to ensure the accuracy of WRAP payment process

DHCF Is One Of Many States Building An Integrated Eligibility System For Insurance And Human Service Programs

- The Affordable Care Act in 2010, gave states the opportunity to replace their legacy and outdated eligibility systems with more modern, federally funded technology

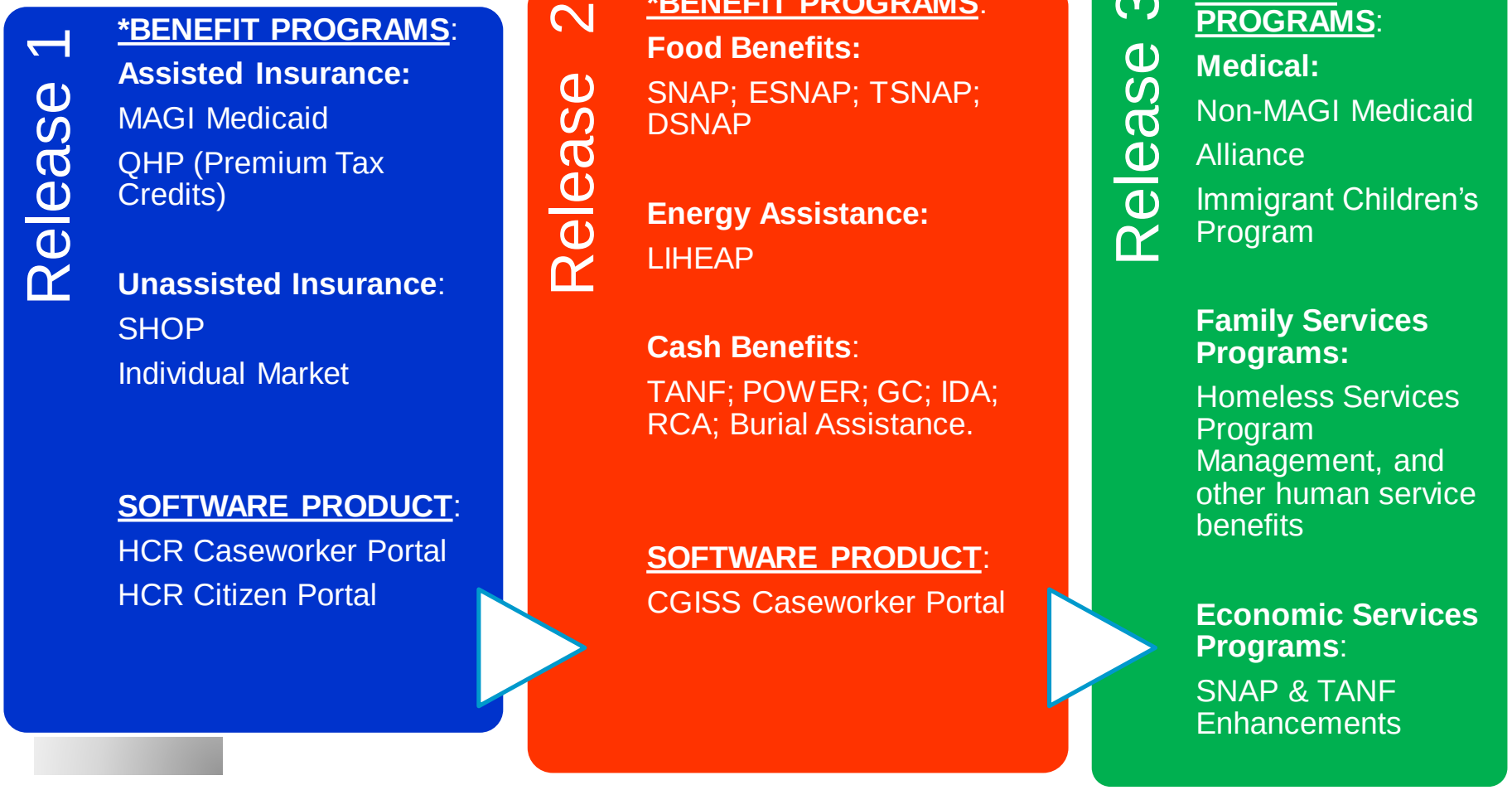
- The vision of DCAS in the District is to provide an integrated eligibility and enrollment platform for health care and human services programs, including –

  - Insurance marketplace
  - Integrated application data functionality, and
  - Enhanced case management capabilities

- When complete, DCAS will facilitate seamless access to health care and human service benefits to all District residents, regardless of income

- The vision for DCAS is ambitious and the project is immensely complex

The Development of DCAS Is Organized In Three Separate Releases



R3 will be implemented in CGISS Case Worker Portal, and launch the CGISS Citizen Portal.

DCAS Was Placed Under The Management Control Of DHCF In 2017

- Due to a confluence of both external and internal agency factors, DCAS has faced barriers to implementation since its inception

- Each phase has experienced major delays in the development of complete system functionality
  - Cross-agency challenges with communication
  - Poor agency coordination
  - Major project governance problems with the project

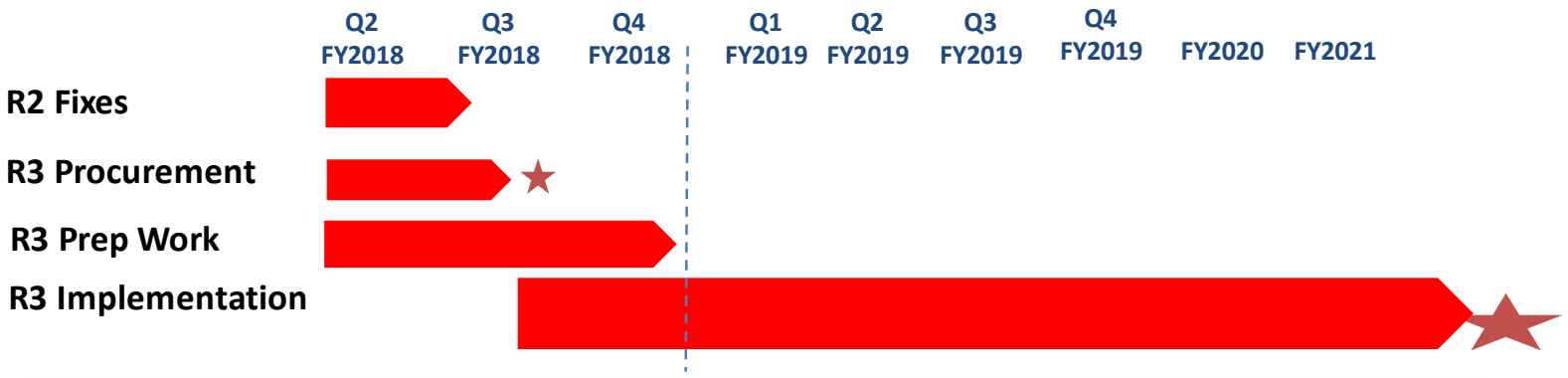
- In June 2017, to facilitate tight alignment of project deadlines, budget, and DCAS deliverables, the City Administrator placed the responsibility for the program under the aegis of DHCF

- Accordingly, DHCF assumed complete responsibility and oversight for DCAS across all three Releases. The scope of responsibility included both application development and operations and maintenance

DHCF Has Developed A Detailed Workplan For The Project And Has Reorganized Project Operations Under A Project Management Office

- First 90 days the DHCF project team focused on the significant operational and design issues that hampered the functionality of R2 by -
  - Taking steps to ensure that R2 system will by fully functional and compliant
  - Establishing a Project Management Office (PMO) to ameliorate technical and programmatic issues
- In the PMO role, DHCF's newly appointed project manager -
  - Conducted a full review of all onsite resources
  - Transitioned more than 60 additional resources to the project
  - Aligned these assets to the correct work stream
  - Identified resources not reflected in the supplied structure, and removed those who needed to be transitioned out of the project
- This realignment has allowed leadership and the budget team to ensure that the cost-allocation required by our federal regulator is accurate

Project Schedule For R2 And R3 With Budget For Last Release



	R3 Projected Budget			
	FY18 Total Cost	FY19 Total Cost	FY20 Total Cost	Total
Federal	$52,454,295	$47,894,070	$28,985,380	$129,333,745
Local	$7,407,306	$46,640,168	$27,904,112	$81,951,586
Total	59,861,601	94,534,238	$56,889,492	$211,285,331

DHCF Has Built A Highly Sophisticated Data Warehouse That Substantially Upgrades Our Data Analysis Capabilities

- With our expanding datasets, DHCF's legacy system could no longer provide efficient access to the files or support the rigorous algorithms we regularly construct to analyze data. System shortcomings -
  - Substandard data query capabilities
  - Limited reporting tools
  - Restricted access to historical claims data
  - Inability to simultaneously pull data from multiple files
- Accordingly we designed a Medicaid Data Warehouse to address these problems and it went live in September 2017. Now –
  - The system offers enhanced functionality and tasks that once took days -- even weeks -- have been compressed into minutes
- We now have -
  - Rapid access to at least 12 years of historical Medicaid and Alliance claims data
  - Interactive reports and dashboards that allow staff to immediately query multiple years of data
  - Pre-built subject-specific reports and dashboards that allow the end-user to select data using a variety of filters and then efficiently array the data by any number of program or patient variables

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- ☑ **Conclusion**

Conclusion

- Mr. Chairman, this concludes my testimony for today

- While significant work remains, DHCF's record of performance over the past 16 months, I believe, has been admirable.

  - Launching a new system of care for a group of beneficiaries with serious health issues
  - Tackling payment reform for providers with whom we spend over $200 million
  - Procuring three managed care plans for a program with a nearly a $1 billion price tag
  - Reorganizing the complex DCAS project, and
  - Significantly enhancing the data management and analytical capabilities of the agency to levels previously unseen are important achievements

- As we move toward the end of FY2018, the team at DHCF looks forward to working with the Committee to address the pressing issues of concern, operating, as always, with complete transparency

- Before I close and yield for the Committee's questions, allow me to briefly address a different issue - the matter of the United Medical Center Board's decision to challenge the request that the record of its deliberations regarding the closure of the obstetrics unit be fully released

Conclusion (continued)

- Chairman LaRuby May believes the issue of whether the Board violated the substantive spirit of the open meeting law is subject to question. As you have agreed, there is an obvious value to having closed meeting deliberations to protect confidentiality on matters covered by the open meeting laws, and the Board will continue to protect that privilege for its deliberations as appropriate

- However, in the spirt of transparency and the hospital's commitment to open government, Chairman May has decided to release both the transcripts and the recordings as soon as they can be expeditiously processed. With this decision, the Board hopes this matter and any question about the value it places on full transparency are soon put to rest

- Allow me to close by thanking you for your leadership and support as well as that of other Committee members

- At this point, my staff and I are happy to answer any questions that you and other Committee members might have. Thank you.